Components of Recovery Support Services Table

Term	Definition or Description
Outpatient Counseling Services	**Description:** Outpatient sites offer flexible intensity of services, based on the severity of clients' risk for relapse. This includes individual, group, vocational, and educational counseling. Convenient hours, including evening and weekend appointments, are available. An important distinction between counseling and coaching (another component of RSS described below) is that counseling involves a clinical evaluation or assessment to define a problem or pathology, the clinician is a trained expert who arrives at a diagnosis and creates a treatment plan designed to address the problem; Counseling will often focus on pain or issues from the past that are causing current problems. The goal of counseling services is to allow the beneficiary to gain: • **Personal autonomy:** Learning to manage stress, unexpected daily events and disruptions, mental health symptoms, relapse triggers and cravings with confidence; develop and pursue leisure and recreational interests, manage free time comfortably; transportation navigation, successfully manage activities of daily living. • **Health:** Developing constructive and comfortable interactions with health-care professionals, Relapse Prevention Planning; managing chronic medical conditions, mental health symptoms and medications; establishing good health routines and practices, and asking for support as needed • **Social Skills:** Engaging with people respectfully, in a culturally appropriate manner,, conversation skills, listening skills and advocacy skills • **Wellness:** Healthy grocery shopping, meal planning, nutrition awareness, and exercise options • **Personal care:** Grooming, sustaining living environment, managing finances and other independent living skills • Assisting the individual with effectively **learning adaptive behaviors** responding to or avoiding identified precursors such as cravings or triggers that result in relapse or functional impairments • Active participation in his/her recovery, through the development of an **Individualized Service Plan** which is recorded,[1] modifiable, and accessible. **Modality:** Counseling Services are a face-to-face intervention which may be provided 1:1 or in groups. Groups should be no larger than 12 individuals per group. **Admissions/Eligibility Criteria:** An individual must have the desire and willingness to receive counseling services as part of his or her individual service plan[2], with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to

[1] For definitions, please refer to the glossary
[2] For definitions, please refer to the glossary

	support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning. RSS counselors hold an appreciation that clients differ in their readiness to change and engage counseling recovery services, and that this readiness may change over time. Individual must meet medical necessary criteria based upon ASAM criteria **Limitations/Exclusions:** Billed daily in 15 minute increments with a limit of 6 units (1½ hours) per day or 65 hours per calendar year. **Staffing Ratio/Case Limits:** Staff to Beneficiary Ratio: 1:10 **Staffing Level/Experience:** Services may be provided by a LPHA or Certified Rehabilitation Counselor (CRC)[3]. **Recommendation**: This RSS component should be ongoing and based on medical necessity and a recovery services plan. It should begin immediately upon discharge from treatment. Services should be launched immediately upon program implementation. **Eligibility:** Individuals must meet medical necessity based upon ASAM criteria.

[3] www.crccertification.com

Recovery Monitoring	*Recovery Monitoring includes Recovery Coaching* Recovery Monitoring: **Definition and Description:** Continuous recovery monitoring (CRM)[4] is a recommended engagement practice based on guidelines for continuing care following primary treatment CRM Counselors discuss post-treatment checkups and continuous recovery monitoring (CRM) during the primary phase of treatment and/or as part of discharge planning. Counselors establish a date and time for the initial call-back appointment with their clients and review the Risk Assessment tool to be used during each follow-up contact. This tool[5], developed by Santa Clara County, contains materials from ASAM, ORS/SRS and the Institute for Research, Education and Treatment in Addiction (IRETA). The tool helps determine a client's recovery status after having successfully completed a primary treatment episode. The idea is to monitor client recovery at specified intervals and to intervene as early as possible should there be signs of relapse potential. The ORS/SRS in the Risk Assessment tool helps the client see behavioral patterns that are related to spiraling back into compulsive drug seeking and use. CRM telephone call-backs for Risk Levels 1 and 2 are not considered counseling. The change in roles and relationships must be firmly established as part of the discharge planning. Rather, this checkup is a brief contact to determine how the client is doing in their recovery and if there is a need to increase type and frequency of contact. For Risk Levels 3 and above, the Immediate Needs Profile Assessment is used as the relapse risk is high and may require some type of treatment.[6] Recovery Coaching **Definition and Description:** Recovery Coaching is delivered by a certified Recovery Coach. The Recovery Coach does not provide counseling or clinical treatment but can support the recovery work and goals the beneficiary may have established in treatment or counseling. Recovery Coaches understand different stages of change and can support beneficiary needs in early, middle and long term recovery as well as support a range of people desiring to change their "using behaviors." The Recovery Coach's role is to support patients in achieving sustained recovery. Recovery Coaching involves facilitating patient access to recovery-oriented substance use disorder treatment, resources, and community recovery groups. Coaching also bridges the segregated treatment system into a more holistic care model through providing support across multiple systems and frameworks of care. There is ongoing patient support regardless of relapse and the beneficiary feels he/she has access to a role model, problem-solver, and advocate. Recovery Coaching helps beneficiaries understand the community culture and helps address any barriers to successful recovery.

[4] https://www.sccgov.org/sites/dads/Continuous%20Recovery%20Monitoring%20-%20CRM/Pages/Continuous-Recovery-Monitoring---CRM.aspx
[5] https://www.sccgov.org/sites/dads/Continuous%20Recovery%20Monitoring%20-%20CRM/Pages/Status-of-Risk-Assessment-Script-for-Continuous-Recovery-Monitoring.aspx
[6] https://www.sccgov.org/sites/dads/Continuous%20Recovery%20Monitoring%20-%20CRM/Pages/Overview-of-Continuous-Recovery-Monitoring.aspx

	Psychosocial Rehabilitation[7] is the recommended program for Recovery Coaching. It is a nationally implemented, community based method of recovery monitoring.[8] Coaching is designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their SUD. Activities included must be intended to achieve the identified goals or objectives as set forth in the Individual's Service Plan. The intent of Recovery Coaching is to restore the individual's functional level to the fullest possible and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. **Modality:** Continuous Recovery Monitoring (CRM) by telephone. Recovery Coaching is a face-to-face intervention with the individual, provided on a 1:1 basis. **Admissions/Eligibility Criteria:** Individual must meet medical necessary criteria based upon recently having been discharged from a treatment program. Individuals must have the desire to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning. Practitioners do well to maintain cases open indefinitely to facilitate a seamless return to recovery services after relapse or other reasons for time away. However, since some data systems will auto-archive patient records after months of inactivity, providers will need to plan around how to ensure timely access to these files. **Limitations/Exclusions:** The total combined hours for Recovery Monitoring & Coaching is 34 hours in a year from first admission into treatment. **Staffing Level/Experience:** Services may be provided by a Peer Recovery Support Specialist Level I/II with supervision by a LPHA or Certified Rehabilitation Counselor (CRC).[9]

[7] http://www.casra.org/psr/what_is_psr.html

[8] http://www.uspra.org/about-pra

[9] For the purpose of Medi-Cal billing, clinical supervision must meet the following requirements and Certified Peer Specialists at Level I and Level II must: receive documented monthly individual clinical supervision by a SUD professional (LCSW, MFT) during the first 2000 hours of work; have 18 hours of documented field supervision by a SUD practitioner during the first 160 hours of contact work with recipients and at least six hours of field supervision quarterly during the following year; have review and co-signature of charting of recipient contacts during field supervision by a SUD professional; and complete continuing education training of at least 30 hours every two years in areas of SUD recovery, SUD rehabilitative services and peer support.

	<u>Staffing Ratio/Case Limits</u>: Staff to Beneficiary Ratio: 1:20. There should also be a supervisory role: A licensed supervisor (Certified Rehabilitation Counselor or other Licensed Professional) should oversee 7-10 unlicensed staff and review documentation weekly. **<u>Recommendation</u>:** This RSS component should be capitated yet begin immediately upon discharge from treatment. These services should be launched upon implementation of the DMC-ODS waiver.
Substance Abuse Assistance	**<u>Definition and Description</u>:** Substance Abuse Assistance refers to the collective community support and treatments available to the beneficiary. Specifically, these are time-limited, goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the Individual Service Plan. The following activities under Substance Abuse Assistance are designed to help individuals with SUD to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. Substance Abuse Assistance includes individualized services coordination designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment. The service may include the following components: • Assist the individual and family members to identify strategies or treatment options associated with the individual's SUD, with the goal of minimizing the negative effects of SUD symptoms or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration • Provide individual and their family supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living • Facilitate participation in and utilization of strengths-based planning and treatments, which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their SUD • Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with

identifying a potential relapse or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning

- Implement interventions using evidence-based and best practice techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom interference with daily activities.

Modality: Substance Abuse Assistance is a face-to-face intervention with the individual and/or family or support system that is provided on a 1:1 basis. Certain components may be carried out by peer support counselors.

Admissions/Eligibility Criteria: An individual must have the desire and willingness to receive recovery services as part of his or her individual service plan, with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning.

Services may help engage individuals with SUD who are unable to receive site-based care or who may benefit from community based services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family in their treatment. As such, Substance Abuse Assistance is recommended and included for individuals who are being discharged from treatment; being released from jail or prisons; or transitioning from crisis services.

Limitations/Exclusions: Services can continue as long as needed, within the limits, based on the individual's needs**.** The total combined hours for Substance Abuse Assistance are limited to no more than a total of 24 hours in a calendar year.

Staffing Ratio/Case Limits: Peer Specialist Level I/II Staff to Beneficiary Ratio: 1:20. There should also be a supervisory role: A licensed supervisor (Certified Rehabilitation Counselor) should oversee 7-10 unlicensed staff and review documentation weekly.

Staffing Level/ or Experience: Services may be provided by Peer Recovery Support Specialist Level I/II, with supervision by a LPHA or Certified Rehabilitation Counselor (CRC).[10]

Recommendation: This RSS component should be capitated and phased-in with an initial focus on high risk groups:

1. Individuals being released from correctional facilities
2. Individuals transitioning from Crisis Units/Services

[10] Ibid.

	3. At Risk Youth with history of non-engagement 4. Individuals with a history of homelessness
Support for Education and Vocational Support Services	**Education and Vocational Support Services** **Description:** Support for education and vocational skills, including linkages to life skills, employment services, job training, and education services, are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education and Vocational Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Supported education may include motivational Interviewing to facilitate and engage the person in identifying their intrinsic motivation in order to activate the choice of going forward in an educational program to increase the opportunity to obtain a job of their choosing. Services are provided to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that that contribute to employability in competitive work environment as well as in the integrated community settings. The individual and his/her employment specialist and support team develop goals which are identified in the individual's person-centered Plan of Care, The outcome of this activity is documentation of the individual's stated career objective and a career plan used to guide individual employment support. Individuals authorized for Education and Vocational Support Services must relate to an employment goal or skill development documented in the service plan. Education and Vocational Support Services must be specified in the service plan as necessary to enable the individual to integrate more fully into the community and to ensure the health, welfare and safety of the individual. **Modality:** Education and Vocational Support Services is a face-to-face intervention with the individual and it is provided on a 1:1 basis. **Admissions/Eligibility Criteria:** The Individual has been assessed to need Education and Vocational Support Services and has a clearly stated interest in obtaining employment with the skills obtained. Supported Education Programs[11] are community

[11] https://cpr.bu.edu/resources/newsletter/supported-education
http://cafetacenter.net/wp-content/uploads/2011/05/SUPPORTED-EDUCATION-white-paper-5-27-11.pdf

	partnerships made up of behavioral health consumers, their network of supporters, agencies, providers and colleges and universities with the intention of pooling resources to maximize educational opportunities and employment outcomes for persons with substance use needs. Supported Education programs modify existing educational environments by making them more receptive and supportive to students with behavioral health needs. Individual must meet medical necessary criteria based upon recently having been discharged from a treatment program and a readiness to actively engage in recovery support services. **Staffing Level/ or Experience:** Services may be provided by a Certified Peer Recovery Support Specialist with supervision by a LPHA or Registered Counselor (SAPC will phase-in requiring a Certified Counselor) • Certified Peer Specialists should have two years of experience supporting individuals in pursuing education goals. • A supervisor requires a minimum of a BA (preferably a Masters in Rehabilitation or a relevant field), a minimum of three years of relevant work experience. All staff should have minimum of two years working in the behavioral health. • Staff should have knowledge in the following areas: disability accommodations and assistive technology, financial aid, student loan default, SUD recovery resources on campus, etc. **Staffing Ratio/Case Limits:** Maximum caseload for a full-time Certified Peer Specialist is 20 clients and respective proportions for part-time staff; the recommended program manager to staff ratio is 1:10. **Recommendation**: This RSS component should be capitated yet begin immediately upon discharge from treatment. These services can be phased after initial implementation of the program. It will be important to ensure demand for this service is monitored closely.
Family Support	**Description:** Family Support involves the training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing instruction and reinforcement of skills learned throughout the recovery process. This includes linkages to childcare, parent education, child development support services, and family/marriage education. This service is provided only at the request of the individual. Family support is a person-centered or person-directed, recovery-oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of their family member with a substance use health disorder. The individual, his or her treatment team, and family are all primary members of the recovery team. For purposes of this service, “family” is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. “Family” does not include individuals

who are employed to care for the beneficiary or live with the individual in a group setting (e.g., sober living). All family support and training must be included in the individual's service plan and for the benefit of the Medicaid covered participant.

Allowable activities include but are not limited to:

- Development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the individual's symptom/behavior management and prevention of relapse. This includes providing tools on problem solving and coping skills and strategies
- Collaboration with the family and caregivers to develop positive interventions to address specific presenting issues and to develop and sustain healthy, stable relationships among all caregivers, including family members, in order to support the participant's recovery. Emphasis is placed on the acquisition of coping skills by building upon family strengths
- Provide family with training/workshops on topics including recovery orientation and advocacy, psycho-education, person-centeredness, recovery orientation, trauma, psychosocial rehabilitation, crisis intervention and related tools and skills such as Individual recovery plans, WRAP, self-care, emotional validation, communication skills, boundaries, emotional regulation, relapse prevention, violence prevention and suicide

Modality: Family Support is a face-to-face intervention which may be provided 1:1 or in groups consisting of family members. Group size cannot exceed 12 individuals.

Admissions/Eligibility Criteria: Individual must meet medical necessary criteria based upon recently having been discharged from a treatment program and a readiness to actively engage in recovery support services. The individual expresses a need, and has a preference for family support and training services. All families and those in the individual's support network are eligible for this service at the discretion of the individual. A release of information from the individual is always required to allow staff to contact significant people, except in cases of threat of injury or death

Limitations/Exclusions: The total combined hours for Family Support are limited to no more than a total of 28 hours in a calendar year.

Staffing Level/ or Experience: Services may be provided by a Certified Counselor.

Staffing Ratio/Case Limits: 1:15 for staff to individual ratio, and 1:16 for groups with family members

Recommendation: This RSS component should be capitated yet begin immediately upon discharge from treatment. These services should be phased-in based on beneficiary risk. Priority initially should be given to:

	1. At Risk Youth 2. People who have a history of homeless 3. Pregnant Women 4. Parents of young Children
Support Groups, *with emphasis on Peer Support Services and Groups*	**<u>Description</u>:** Peer Support Services and Groups are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from a behavioral health disorder. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Individualized Service Plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist individuals in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Individuals providing these services will do so through the paradigm of the shared personal experience of recovery. There are 6 categories of peer-support components. They include: 1. **Advocacy**: • Assisting recipients in seeking and obtaining benefits and entitlements, food, shelter, permanent housing • Assisting recipients in participating in shared decision making (e.g. MyPSYCKES) • Linkage to and systems navigation within behavioral health and allied human services systems to access appropriate care (e.g. Peer Bridgers) • Benefits advisement and planning • Assistance advocating for self-directed services 2. **Outreach and Engagement**: • Companionship, advocacy, support and modeling of recovery lifestyle, including participation in recovery activities that might be beyond the scope of treatment providers (e.g., eating together at a restaurant, attending or participating in a sporting event, attending a social event such as a concert or recovery celebration event) • Raising the awareness of existing services, pathways to recovery and helping a person to remove barriers that exist for access to them

- Interim visits with individuals after discharge from Hospital Emergency Rooms, Detox Units or Residential Treatment Units to facilitate community tenure and increased readiness while waiting for the first post-discharge visit with a community-based SUD service provider. If possible, contact is established before discharge to enhance the probability of adherence and follow-through.

3. **Self-help tools:**
   - Assist selecting and utilizing self-directed recovery tools such as Relapse Prevention Planning
   - Assist selecting and utilizing the things that bring a sense of passion, purpose and meaning into his/her life and coaching the person as they identify barriers to engaging in these activities
   - Assist individuals to help connect to natural supports that enhance the quality and security of life
   - Connecting individuals to "warmlines"
   - Connections to self-help groups in the community
4. **Recovery Supports:**
   - Recovery education and coaching for individuals and their family members
   - One-to-one peer support
   - Person-centered goal planning that incorporates life areas such as community connectedness, physical wellness, spirituality, employment, self-help
   - Assisting with skills development that guides people towards a more independent life
5. **Transitional Supports:**
   - Bridging from residential treatment to an individual's
   - Bridging from homelessness to housing
6. **Pre-crisis and Crisis Supports:**
   - Providing companionship when an individual is in an emergency room or crisis unit or preparing to be admitted to detox, residential or other service to deal with crisis
   - Providing peer support in the individual's home or in the community to support them before (or in) a crisis or relapse
   - Developing crisis diversion plans or relapse prevention plans

Modality: Peer Support Services is a face-to-face intervention which is provided 1:1.

Admissions/Eligibility Criteria: Individual must meet medical necessary criteria based upon recently having been discharged from a treatment program and a readiness to actively engage in recovery support services. Peer support is voluntary, subject to periodic review of goals, readiness for commitment to participate, and based on medical necessity.

	Limitations/Exclusions: The total combined hours for Peer Support are limited to no more than a total of 65 hours in a calendar year. Peer services while an individual is incarcerated or institutionalized are not Medi-Cal reimbursable. The cost of admission to an event (i.e., sports event or concert) is not Medi-Cal reimbursable. **Staffing Level/ or Experience:** Services may be provided by a Certified Peer Specialist (CPS) Level I/II and supervised by a LPHA or Certified Counselor. The Peer uses his or her lived experience of recovery from addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency. For the purpose of Medicaid billing, clinical supervision must meet the following requirements. Certified Peer Specialists at Level I and Level II must: • Receive documented monthly individual clinical supervision by a SUD professional during the first 2000 hours of work. • Have 18 hours of documented field supervision by an SUD professional or SUD practitioner during the first 160 hours of contact work with recipients and at least six hours of field supervision quarterly during the following year • Have review and co-signature of charting of recipient contacts during field supervision by a LPHA • Complete continuing education training of at least 30 hours every two years in areas of mental health recovery, mental health rehabilitative services and peer support **Staffing Ratio/Case Limits:** Peer Specialist Level I/II Staff to Beneficiary Ratio: 1:20. There should also be a supervisory role: A licensed supervisor (SUD professional) should oversee 7-10 unlicensed staff and review documentation weekly. **Recommendation**: This RSS component should be capitated yet begin immediately upon discharge from treatment. These services should be launched immediately upon implementation of the ODS waiver.
Ancillary Services	**Description:** Ancillary services, such as linkages to housing assistance, transportation, and case management, are provided on a 1:1 basis and are designed to assist individuals with an SUD in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist individuals with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating and obtaining housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate fully into the community and ensure recovery, health, welfare, safety and maximum independence of the participant. **Modality:** Ancillary service is a face-to-face intervention with the individual and it is provided on a 1:1 basis.

	Admissions/Eligibility Criteria: Individual must meet medical necessary criteria based upon recently having been discharged from a treatment program and a readiness to actively engage in recovery support services. The beneficiary must require habilitation and onsite services that may include, but are not limited to: cognition (cognitive skills), functional status (ADLs), and recovery-oriented community support. **Limitations/Exclusions:** The total combined hours for Ancillary Services are limited to no more than a total of 37 hours in a calendar year. **Certification/Provider Qualifications:** Services are provided by Certified Peer Specialist (CPS) Level I/II and supervised by a LPHA or Certified Counselor. For the purpose of Medicaid billing, clinical supervision must meet the following requirements. Certified Peer Specialists at Level I and Level II must: • Receive documented monthly individual clinical supervision by a SUD professional during the first 2000 hours of work. • Have 18 hours of documented field supervision by a SUD professional or mental health practitioner during the first 160 hours of contact work with recipients and at least six hours of field supervision quarterly during the following year • Have review and co-signature of charting of recipient contacts during field supervision by a SUD professional or mental health practitioner • Complete continuing education training of at least 30 hours every two years in areas of mental health recovery, mental health rehabilitative services and peer support **Staffing Ratio/Case Limits:** Staff ratio of 1:20 or less; Supervisory ratio: 1:10 (1 supervisor to 10 Direct Care Staff) **Recommendation**: This RSS component should be capitated yet begin immediately upon discharge from treatment. These services should be phased in, with high priority initially given to the following groups: 1. Individuals with co-occurring illness 2. Individuals being released from correctional settings 3. At risk Youth with developmental/intellectual deficits 4. Individuals with a history of homelessness

Summary of Common RSS Staffing Titles

RSS Service Component	RSS Title(s)	Recommended Staff to Beneficiary Ratios	Limitations: Service Hours per calendar year
Outpatient Counseling	Certified Rehabilitation Counselor (CRC) or Licensed Practitioner of the Healing Arts (LPHA)	1:10	65
Recovery Monitoring	Certified Peer Specialist (CPS) Level I/II with Certified Rehabilitation Counselor (CRC) Supervisor	1:20 (1:7 for Supervisory)	34
Substance Abuse Assistance	Certified Peer Specialist (CPS) Level I/II with Licensed SUD professional Supervisor	1:20 (1:7 for Supervisory)	65
Education/Job Skills	Education Specialist with Certified Supervisor	1:10	27
Family Support Services	Certified Counselor	1:15	28
Support Groups	Certified Peer Specialist (CPS) Level I/II with LPHA Supervisor or Certified Counselor	1:20 (1:7 for Supervisory)	65
Ancillary Services	Certified Peer Specialist (CPS) Level I/II with LPHA Supervisor or Certified Counselor	1:20 (1:5 for Supervisory)	37
		TOTAL FOR ALL RSS SERVICES:	**321**

Certified Rehabilitation Counselor (CRC) is certified with a national Certified Rehabilitation Counselor (CRC) designation by The Commission on Rehabilitation Counselor Certification (CRCC) that sets the standard for quality rehabilitation counseling services in the United States and Canada

To be employed as a Certified Peer Specialist (CPS) Level I, an individual must meet all of the following criteria:

- Must be at least 21 years old.
- Have a high school diploma or equivalent.
- Have or have had a primary diagnosis of substance use disorder or co-occurring mental illness-SUD.
- Have received or is currently receiving SUD or mental health services.
- Be willing to share their experience of recovery.
- Successfully complete the SAPC approved Certified Peer Specialist training and certification exam.

To be employed as a Certified Peer Specialist (CPS) Level II, an individual must meet all of the qualifications of a Certified Peer Specialist Level I and meet one or more of the following:

- Have at least 6,000 hours of supervised experience in the delivery of peer services to persons with SUD

• Have at least 4,000 hours of supervised experience in the delivery of services to persons with SUD or mental illness and an additional 2000 hours of supervised experience in the delivery of peer services to persons with SUD.

Certification will remain valid for two years from the time of attaining certification. This will be monitored by SAPC. To retain certification, every two years, Peer Specialists must complete and provide documentation of 30 hours to SAPC of continuing education in areas of SUD/mental health recovery, rehabilitative services, and peer support. Certified Peer Specialist services will have the same threshold as other mental health rehabilitative services. The current threshold is 300 hours of service per year per service recipient.

Supervision of Certified Peer Specialists (CPS)

- As County requirements, clinical supervision must meet the following requirements. Certified Peer Specialists at Level I and Level II must:
- • Receive documented monthly individual clinical supervision by a SUD professional during the first 2000 hours of work.
- • Have 18 hours of documented field supervision by a SUD professional or mental health practitioner during the first 160 hours of contact work with recipients and at least six hours of field supervision quarterly during the following year.
- • Have review and co-signature of charting of recipient contacts during field supervision by a SUD professional or mental health practitioner.
- • Complete continuing education training of at least 30 hours every two years in areas of SUD recovery, SUD rehabilitative services and peer support.
- Amount, Duration and Scope of Service

Limitations on Services

Below is a proposed distribution of service hours for RSS in a calendar year.

RSS Service Component	Q1 Hours	Q2 Hours	Q3 Hours	Q4 Hours	Total per Calendar Year
Outpatient Counseling	26	13	13	13	65
Recovery Coaching	6	6	6	6	24
Substance Abuse Assistance	26	13	13	13	65
Education/Job Skills	0	13	7	7	27
Family Support Services	13	7	4	4	28
Support Groups	26	13	13	13	65
Ancillary Services	13	13	7	4	37
				TOTAL FOR ALL RSS SERVICES:	**321**

Glossary of Terms:

Term	Definition or Description
12-Step-Oriented Group Counseling	**Not a covered benefit.** This is the most common type of formal continuing care based on the 12-step principles. Although the programs are not standardized, they all focus on the 12-step principles underlying self-help groups. During the sessions, participants typically report on their current status (e.g., illicit drug use) as well as their progress towards working through the 12 steps. Other components may include feedback and support from other group members and sponsors as well as planning of drug-free leisure activities for the upcoming days. The planned duration of this type of continuing care generally is 3 to 6 months; however, dropout rates are high, and most studies have found that approximately 50 percent of patients stop participating before 3 months.[12] Additionally, studies have found the benefit of support groups among youth is inconclusive as participation in self-help groups among youth tends to be low.
Employment Specialist	Employment specialists offer assistance in matching people with jobs that fit their skills and interests. In some cases, employment specialists work for companies, recruiting employees or developing new human resources policies. Other employee specialists, often called supported employment specialists, provide job assistance to individuals with a physical disability or mental illness. These positions usually require a bachelor's degree.
Face to Face	Occurring in person at a certified facility. Telephone contacts, home visits, and hospital visits are not considered face-to-face.
Group Counseling	Face-to-face contacts in which one of more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individuals served.
Illicit Drug	Any substance defined as a drug in Section 11014, Chapter 1, Division 10 of the Health and Safety Code, except: (A) Drugs or medications prescribed by a physician or other person authorized to prescribe drugs, pursuant to Section 4040, Chapter 9, Division 2 of the Business and Professions Code, and used in the dosage and frequency prescribed; or (B) Over-the-counter drugs or medications used in the dosage and frequency described on the box, bottle, or package insert.
Individual Counseling	One-to-one contacts between a beneficiary and a therapist or counselor.
Individual Service Plan	A Recovery Plan developed collaboratively between the individual, or individual's parent or legal representative if applicable, and Mental Health Care Provider that results in a person-centered, strength-based plan that meets the individual's unique mental health needs.[13]
Intake	The process of admitting a client into a substance use disorder treatment program and includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral or substance use disorders; the diagnosis of substance use disorders using the DSM-5; and the assessment of treatment needs to provide medically necessary treatment services by a physician. May include a physical examination and laboratory testing.

[12] http://pubs.niaaa.nih.gov/publications/arh334/356-370.htm

[13] For an example of an Individual Service Plan, visit: http://www.dhs.state.il.us/page.aspx?item=66670

Licensed Practitioner of the Healing Arts (LPHA)	A Licensed Practitioner of the Healing Arts (LPHA) possesses a valid California clinical licensure or certification in one of the following professional categories: Medical Providers: MD, DO, PA, APN: (NP, CNS); Registered Nurse; Licensed Clinical Psychologist; Licensed Clinical Social Worker; Licensed Marriage and Family Therapist; Licensed Professional Clinical Counselor.
Medical Necessity	In order to receive services through the DMC-ODS, the beneficiary: • Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; **or be assessed to be at risk for developing substance use disorder (for youth under 21).** • ii. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. • iii. If applicable, must meet the ASAM adolescent treatment criteria. As a point of clarification, beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements.
Medical Psychotherapy	A type of counseling services defined in Section 10345 of Title 9, CCR.
Medication	Any opiate agonist medications that have been approved for use in replacement narcotic therapy
Medication Services	The prescription or administration of medication related to substance use disorder treatment services or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or laboratory testing within the scope of their practice or licensure.
Medication Unit	A narcotic treatment facility, established by a program sponsor as part of a maintenance treatment program, from which licensed private practitioners and community pharmacists are permitted to administer and dispense medications used in replacement narcotic therapy. These medication units may also collect patient body specimens for testing or analysis of samples for illicit drug use.
Methadone	The substance that can be described as 6-dimenthylamino-4, 4- diphenyl-3-heptanone. Methadone doses are usually administered as methadone hydrochloride.
Motivational Interviewing	Motivational Interviewing focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. The method differs from more “coercive” or externally-driven methods for motivating change as it does not impose change (that may be inconsistent with the person's own values, beliefs or wishes); but rather supports change in a manner congruent with the person's own values and concerns.

Peer Support	Peers give and receive nonprofessional, nonclinical assistance to achieve long-term recovery for beneficiaries. The support is provided by individuals who have experiential knowledge. Peers provide assistance to promote a sense of belonging within the community. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.
Physical Dependence	A condition resulting from repeated administration of a drug that necessitates its continued use to prevent withdrawal syndrome that occurs when the drug is abruptly discontinued.
Professional staff	Practitioners possessing a license or a permit from the California Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness and substance use disorders.
Recovery Community Center	Recovery Community Centers (RCCs) are places where a wide range of the above listed peer services can take place. A user-friendly website that helps beneficiaries search for RCCs by location and characteristics (e.g. 12-Step, Christian, gender, etc.) supports the self-management aspect of recovery by allowing individuals make their own decisions and commitment. Alternatively, the recovery support specialist can be the representative who responds to the initial request for services and engages the beneficiary by offering a choice of agencies where they can engage in RSS.
Recovery Services	Services under Substance Use Disorder (SUD) Treatment which: • Allow for a process of change through which individuals can improve their health and wellness, live self-directed lives, and strive to reach their full potential; • Are supported through relationships and social networks; • Are highly individualized and culturally relevant
Relapse	A single instance of a client's substance u se o r a client's return to a pattern of substance use.
Relapse Prevention	A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
Relapse Trigger	An event, circumstance, place or person that puts a beneficiary at risk of relapse.
Remission	A state of wellness where there is an abatement of signs and symptoms that characterize active addiction. Many individuals in a state remission state remain actively engaged in the process of recovery. Reduction in signs or symptoms constitutes improvement in a disease state, but remission involves a return to a level of functioning that is free of active symptoms and/or is marked by stability in the chronic signs and symptoms that characterize active addiction.
Substance Use Disorder Diagnoses	Those set forth in the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association.

Therapist	Any of the following: 1) a psychologist licensed by the California Board of Psychology; 2) a clinical social worker or marriage and family therapist licensed by the California Board of Behavioral Sciences; 3) an intern registered with the California Board of Psychology or the California Board of Behavioral Sciences; or 4) a physician.
Warmline	A peer-run listening line staffed by people in recovery themselves. Compared to hotlines they are generally not focused on crisis intervention and not staffed with licensed clinicians. They are also generally not 24-7, but there is significant variation across the country. They are intended to be a non-emergency resource that complements hotlines. Many consumers prefer not to call hotlines because they fear they will be committed and that doctors will show up at their door.